

1 KAMALA D. HARRIS
Attorney General of California
2 GLORIA A. BARRIOS
Supervising Deputy Attorney General
3 LINDA L. SUN
Deputy Attorney General
4 State Bar No. 207108
300 So. Spring Street, Suite 1702
5 Los Angeles, CA 90013
Telephone: (213) 897-6375
6 Facsimile: (213) 897-2804
Attorneys for Complainant
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8 **BEFORE THE**
BOARD OF REGISTERED NURSING
9 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

10 In the Matter of the Accusation Against:

Case No. 2013-660

11 **KATHY ELAINE BENNETT**
12 **1335 Newport Avenue, No. 107**
13 **Long Beach, CA 90804**

A C C U S A T I O N

14 **Registered Nurse License No. 712632**

15 Respondent.

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17 Complainant alleges:

18 **PARTIES**

19 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her
20 official capacity as the Executive Officer of the Board of Registered Nursing (Board),
21 Department of Consumer Affairs.

22 2. On or about September 18, 2007, the Board issued Registered Nurse License Number
23 712632 to Kathy Elaine Bennett (Respondent). The Registered Nurse License was in full force
24 and effect at all times relevant to the charges brought herein and will expire on December 31,
25 2014, unless renewed.

26 **JURISDICTION**

27 3. This Accusation is brought before the Board under the authority of the following
28 laws. All section references are to the Business and Professions Code unless otherwise indicated.

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9. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

COSTS RECOVERY PROVISION

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

PATIENT G.F.

11. From about 2007 to 2011, Respondent was employed as a day shift (7 am to 7 pm) registered nurse in the Medical-Surgical Unit of Beverly Hospital. On or about June 18, 2011, seventy-nine year-old Patient G.F. was admitted to the hospital's Emergency Room with complaints of weakness, dizziness and diarrhea. Patient G.F. had a history of asthma, chronic kidney disease, anemia, stroke, dementia, coronary artery disease with angioplasty, congestive heart failure, urinary tract infection and hyperlipidemia. She was admitted with a low hemoglobin of -10.3g/dL (normal range 12.0-14.0), and low hematocrit of -31.9% (normal range 37.0-42). Her serum B-type Natriuretic Peptide (BNP) level was 3,642, while the normal range for this diagnostic indicator for heart failure is 5 to 450.

12. While at Beverly Hospital, Patient G.F.'s primary physician, Dr. Emmanuel Mojtahedian, consulted with numerous medical specialists, including hematology specialist Dr. Ira Felman, to manage the care of the patient. During her stay, Patient G.F. underwent several invasive procedures which included an upper and lower endoscopy which revealed severe atrophic gastritis and severe pseudomembranous colitis associated with positive C.Difficile infection. Patient G.F. was placed on contact isolation for her positive C.Difficile stool cultures.

13. On or about June 22, 2011, Patient G.F. had an inferior vena cava filter placed due to an extensive right lower extremity deep vein thrombosis. A percutaneously-inserted central catheter (PICC) was placed in her right upper arm in order to establish intravenous access.

14. On or about June 24, 2011, Patient G.F. was transferred to the Medical-Surgical Unit.

15. On or about June 27, 2011, Respondent was assigned to care for Patient G.F. At about 1728 hours, Dr. Felman gave a telephone order to Respondent and ordered two units of packed red blood cells (PRBC) for "type and crossmatch" for Patient G.F. No order to transfuse the blood was given to Respondent. Patient G.F.'s hemoglobin and hematocrit levels were at 8.8/27.2. At the end of Respondent's shift, she endorsed to the oncoming night shift nurse C. Cuellar that Patient G.F. "has to receive PRBC's". Upon RN Cuellar's assessment of Patient G.F., he noticed that the patient's IV (intravenous) had infiltrated and he was not able to restart another IV. RN Cuellar called Dr. Felman who then instructed RN Cuellar to call Dr.

1 Mojtahedian for further orders. At about 2250 hours, Dr. Mojtahedian gave RN Cuellar a
2 telephone order to "Hold IV PRBC", and ordered the patient to be left without an IV until the
3 next day. At about 2325 hours, RN Cuellar transcribed the orders onto the patient's chart.
4 Patient G.F.'s BNP was 3403 on this day.

5 16. On or about June 28, 2011, at the end of RN Cuellar's shift at 0700 hours, RN Cuellar
6 reported to Respondent that the order for the PRBC's was on hold and not to transfuse blood. At
7 about 0935 hours, Respondent took a telephone order from Dr. Mojtahedian for a "STAT PICC
8 line placement" for Patient G.F. Respondent read back the order to Dr. Mojtahedian. At 0945
9 hours, Respondent witnessed a Spanish language consent for a PICC line placement and there is
10 another one for blood transfusion but with the time missing. Both consent forms were incomplete
11 with the relationship of the signator to the patient absent.

12 17. On or about June 28, 2011, the PICC line was inserted. At about 1825 hours,
13 Respondent ordered the PRBC's from the blood bank. At about 1845, Respondent started the
14 blood transfusion, 15 minutes before the end of her shift. At about 1900 hours, Dr. Felman
15 noticed that Respondent started the transfusion without an order. At about 1930 hours, Dr.
16 Felman wrote an order to transfuse one unit of PRBC's. At about 2230 hours, the transfusion was
17 completed.

18 18. On or about June 30, 2011, Patient G.F. presented with rales (lung sounds) in her
19 right lower lobe, which is indicative of fluid overload. On or about June 30, 2011, Patient G.F.'s
20 BNP rose to 5668.

21 **FIRST CAUSE FOR DISCIPLINE**

22 **(Gross Negligence)**

23 19. Respondent is subject to disciplinary action under Code section 2761, subdivision
24 (a)(1), in conjunction with California Code of Regulations, title 16, section 1442, on the grounds
25 of unprofessional conduct, in that on or about June 28, 2011, Respondent committed gross
26 negligence in her care of Patient G.F. The circumstances are as follows:

27 20. Respondent failed to verify the physician's order before starting a blood transfusion
28 on Patient G.F. near the end of her shift.

21. Complainant refers to and incorporates all the allegations contained in paragraphs 11 – 18 above, as though set forth fully.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

22. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), in conjunction with California Code of Regulations, title 16, sections 1443 and 1443.5, on the grounds of unprofessional conduct, in that on or about June 28, 2011, Respondent was incompetent in her care of Patient G.F. The circumstances are as follows:

23. Respondent failed to obtain a complete and thorough Informed Consent from Patient G.F. about the blood transfusion.

24. Complainant refers to and incorporates all the allegations contained in paragraphs 11 – 18 above, as though set forth fully.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 712632, issued to Kathy Elaine Bennett;

2. Ordering Kathy Elaine Bennett to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: February 21, 2013

for Stacie Bern
LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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